COLORADO
Department of Health Care Policy & Financing

Community First Choice Development and Implementation Council

Draft Minutes for March 2, 2015

Date and Time: Monday, March 2 2015, 1:00-3:00pm
Location: First Floor Conference Room, 225 E 16th Ave. Denver, CO 80203

Purpose: To produce recommendations for future CFC feasibility study.
Products: A list of recommendations that address how CFC contractor(s) can effectively build on the initial Community First Choice feasibility study.

Call-in Instructions:
1. Dial the Participant Access Number 877.820.7831
2. Enter the Participant Passcode: 511120# (remember to include the # sign)

Attendance:

In the Room:

- Grace Herbison – HCPF
- Whitney Ray – HCPF
- Jen B. – Alliance
- Ed Milewski – Consumer and Center for Disabilities Boulder
- David Bolin - Center for Independence
- Adam Tucker - HCPF (DIDD)
- Lori Thompson - HCPF (DIDD)
- Julie Reiskin - CO Cross Disability Coalition, HCBS, CDASS, IHSS
- Anaya Robinson - Atlantis Community

- Tim G. - HCPF
- Marijo Rhymer – Arc of CO
- Ryan Martin - HCPF
- Joanne – HCPF
- Candie Dalton - HCPF
- Carol Meredith - The Arc of Douglas County
- Josh Winkler - CFC Co-Chair
- Pat Cook - Colorado Gerontological Society

On the phone:

- Chandra Matthews - CO Access
- Barry Rosenberg - Halley House
- Gina - unknown

Review minutes from January 2015

Candie did minutes for January - let her know if missed something. David Bolin says minutes look good.

Information Brett was talking – if missed anything - let her know. Motion to approve. Approved.

Discuss the Contractor from January 2015 Meeting

Grace: Reviewing the experience of the first feasibility analysis- with potentially having a new contractor - feedback isn't just focused on contract - but timeframes and communication. Grace would like feedback… what could contractor have done differently?

Grace talked about the budget request and what pertains to CFC - main points of potential new contract

Conduct regulatory review

Conduct stakeholder outreach - and nurse practice act and payment to family members

Start with processing of what worked - working with the contractor

Josh Winkler: Contractor had good knowledge of the Medicaid rules. And not Colorado's rules but Medicaid in general. Good relationship and open communication with Contractor.

Grace: Good Knowledge (first white board outline)

Maryjo R: Simultaneous and working on project for waiver simplification and did learn about Colorado's system. Work with specific project for CLAG. Concept paper regarding waiver simplification was done well.

Thinking about the contractor or what the council did well to add?

Julie Reiskin: Some things we couldn't change because we didn't have the knowledge.
Some consultants brought in - too late to have any affect. Things that we could change, we didn't know them to change.

Josh Winkler: Before they make data request – they started working with stakeholders. The communication was good. At the end it was rushed. But it was good. It was a lot of information to throw at us. The November meeting was them showing us the model and asking for feedback.

Grace: would you potentially want time to review the irritations and then give feedback

Josh: not necessarily the whole report - being involved in reviewing the data. Asking them why you would think this assumption.

Julie: What are the bucket areas - we were meeting monthly - and it's something to consider. Designate – three people for different buckets. But not being monthly, and not going back to monthly meetings, this may not work this time.

Grace: Being involved in reviewing the data. Identify sub-committees and key experts, people we contact on certain issues.

Julie: To clarify: People who we contact on certain issues.

Josh: the timeframe – a lot of work going on, with the numbers and putting together the numbers.

Ed Milewski: To asses Case management and AWC (Instead of going through the Independent Living Society) – we have an older county with health care management incorporated and as an individual consumer, you get to comment on the services. The person actually giving the service. You talk to an independent person, and could have another level of comment.

Someone other than the agency - providing the service and you get to comment, someone who is at the county or state level and that makes sure things are going right with you. Someone who is not the SEP and at the county or state level.

Also someone to assess the service, evaluation of the case manager, someone to asses that is not the service contractor worker, but rather someone at the state level that is not the SEP.
They commented on Case Management and that evaluation wasn't wanted by the agency giving the service.

But to have the state evaluate the agency.
Someone county or state wide and not the providers.
Case management services should be state wide, and not by the agency that's doing it.
Third Party.

Josh Winkler: the feds are making this change and it should be happening across the board

Julie Reiskin: other pieces of the report that we need to handle

Grace: Let's look at the product of the report and then get back to everyone. Had procurement with the contractor per year in the RFP. Potential other alternatives—but a limit for how much could be spent on that – Price agreement list. If we use Mission, to start work- could be precluded from working on the rest of the contract- or if we don't have to go through the request we could get someone to start sooner. If we have to do an RFP, there unlikely until we have the money approved. We can start developing a list and work on the deliverables. We think they will approve. Based on feedback from everyone, we see everyone had a positive experience working with Mission.

Maryjo: It was a steep learning curve and having to re-invent. Having a lot of same committee members with a new contractor. Not a good use of time or money.

Pat Cook: Look for a contractor that has experience with other states, specifically with this project.

Grace: have some experience working with other states

Grace: Some states did have personal care, Texas had Personal Care in the state plan. But didn't serve people with intellectual disabilities. Connecticut has it in state plan but not on all their waivers. Anything to add what worked well?

Pat Cook: This group has been together for three years, we have a lot of trust and willingness in the group.

Josh: Coming here and face to face… vs. over the phone and the face to face. Working with the contractors.

Grace: <u>What else to add being involved reviewing the data? The counsel? Evaluating Case Management Services</u>

Ed Milewski: County or state… instead of agency.

Having experience with CFC in other states, changes, to recommend moving forward?

Julie: What was frustrating last time- being able to have parameters and have secondary questions, can we do it once? Have the preliminary data. If we add behavioral services… 10% to 20% if we added and personal care include…. What effect would this have on this?

Grace: have a mid-point and ask the questions

Carol: The factors that they were based on, what evidence was there to back that up?

Julie: That would be a longer meeting. The variables, the factors, where they came from and what backs this up. Have these discussions. Here's the data we used. Have time more than 30 minutes.

Grace: give feedback… explain clearly how they were using the numbers and variables.

Josh: We understood the several they showed us and that was the way it was shown. And it was a dynamic model. By name what the variable would be and what they are.

Grace: Better understanding of what the variables are and have a midpoint to evaluate and make recommendations. Experience with CFC in other states.

Julie: Could we test some of these and 50% goes to personal care and we think something else and why… would be helpful in terms of the assumptions. Has to be some cut off. And find a happy medium but find someone who would hold us accountable for not asking too much.

Pat Cook: And understand the matching dollar program, what actually is matching and what isn't? Getting them re-prioritized.

Lori: certain things we asked CMS. Supporting a claim?

Grace: Allow to ask questions and make modifications for the projections

Maryjo: Would like to see future reports the cost of voidance- some of the data is hard to come by. Speculations about the cost. Cost of voidance. And important to understand and see what those are, and understand the economic impact. I don't think we asked them to do this in the report.

Grace: Overall economic impact- on cost of living, and on all 3 factors

Carol Meredith: CFC in place, you will have some cost savings in the waivers. And maybe in home health and health maintenance. Has a dual purpose. Especially for people in assisted living. We call it so many different things. How do you not duplicate the cost on one side? We have many different definitions for personal care services. Bill as a personal care service, under residential or… We don't know what those costs are.

Candie: Substitution and if we start services over here and the cost shifting to another place

Carol: We have 10 diff definitions of personal care service. What is billed in an assisted living facility?

Mary Jo: Allow the contractor to give us some educated estimates and the cost of living in those systems.

Lori: Self-directed and state plan. Can't make that direct assumption because of the different personal care definitions.

Grace: Understanding how services are defined. To understand what services might be substituted for other services. Unifying definitions. Direct substitution. Find evidence.

Carol: Calling everything the same thing but it's not the same thing (ex-calling something "behavioral services")

Grace: and look at service definitions and how it's different by waiver.

Pat Cook: Do we have any concept or any ideas of what it would cost to administer the CFC program?

Julie: the quality expectations are higher.

Pat Cook: Will be important to convince the legislatures to support this.

Candie: As far as looking at cost projection, when we get the point what we put forward for the cost of the program and we can request FTE and explain why we need those FTE.

Mary Jo: if you're moving those FTE

Julie Reiskin: Look at what it takes to manage it properly. Appropriately manages this and this is a policy decision. No wavering. Have someone other than HCPF from out of state. Here's what it takes to manage this properly this reduces the FTE. At times the FTE was not an accepted word. We don't want to get to that point of badly running programs

Candie: Agree with the external component. The implementation piece. Staff intensive and back off the heavy resources

Julie: And sometimes in the past we've backed off the heavy resources too soon

Grace: Look at cost savings and cost of administration and what needed to administer the program.

Pat Cook: How to work with the political arm and nurse practice act issues. And non-licensed people.

Grace: Recommendation on how a contractor could help with this?

Pat Cook: Focus groups that work in the industry- and people- with nurses and people who work in the direct industry…. Risk Management. Find out what ER health is and help… and people who are sent to ER inappropriately. Go down to the bottom and work with the front line workers. People who have across the board state scope

Lori: Include in the focus groups the CANDD who work with them

Josh: Agree.

Pat Cook: have representation from the front too and really get abroad view point here.

Candie: for people on the phone – what worked well working with mission and what going forward?

Barry Rosenberg: There has been some progress of CNAs that nurses were doing in the past, the board of nursing has been supportive. The only opposition there was with trial lawyers. Something to work on.

Grace: We will consider this moving forward as far as the Nurse Practice Act.

Gina: I appreciate the value and bringing another value entity into this.

Carol: I think this time out, we might have at least a little bit of information about uptakes. People who were waiting for a long time to get services and they are now getting services. We should be able to get some data on this and the woodwork effect.

Lori: We have the wood work effect in CES and no wait list.

Carol: CFC has the same potential.

Lori: makes a very good point and what their utilization of personal care is and implement this data

Carol: A lot of those people are gone. We will get a better state update this time.

Pat Cook: How many people to transfer to the program…are you currently served

Josh: Services moved from waiver to state plan. Have to take state plan. Wouldn't be an option.

Pat Cook: if they knew when the services were available.

Carol: That it's from a personal centered and self-directed model.

Pat Cook: how many people are on the wrong waiver?

Grace: look at new data on the wood work effect and update clients with the new services (specifically SLS waiting list, with different data too)

Candie: to Josh- EPSDT in personal care changes.

Carol: Another benefit coming online we hope

Grace: Incorporate data coming up on EPSDT

Candie: how exactly did mission break it out. And make it go through EPSDT.

Josh: agreed upon that this is required.

Lori: not all get there benefits from EPSDT.

Josh: not only does this get wiped away from the cost of CFC. 6% on top.

Lori: EPSDT is the state plan for kids…

Josh: would EPSDT would kick in if limit was set in at 30 hours a week? And capped hours at 30 hours per week for EPS—and cap it at 30 and a kid needed 40- the state pays for EPSDT is first. And bill it all as CFC. And then the waiver picks it. Get clarification on this. Under EPSDT it has to be medically necessarily. CAP cannot be based on age, location, etc; as long as it's medically necessary.

Lori: It is kid version of the state plan for EPSDT.

Candie: We can get policy guidance on the relation between the two.

Pat Cook: Evaluate how PDN would impact this as well. How PDN takes place with personal care.

Grace: How would EPSDT protect CFC? Anything to add before we move on to number 4. Did anyone have time to review the report that was sent out? Anyone see the comments Grace put together?
Carol: Yes, the comments were very helpful.

Grace: Yes large portions of it are more historic.

Pat Cook: Do we have good support from the upper management/leadership?

Candie: Leadership point of CFC has not changed. After doing it for 2 ½ or 3 years. Jed feels very strongly on the desire to make it happen and embraces it. The price tag is what to consider.

Julie: And the support has increased a lot. Evolved and changed in positive way.

Lori: the fore front is person centeredness and it being an entitlement. The volume of new people enrolled.

Pat Cook: Residency Requirements too. A level of care associated with it and people who move here and come here for a week. If you're here. You're eligible.

Julie: The medically necessity requirements.

Lori: They have to have it.

Candie: Medicaid has to be continuous and get it right away if you move.

The Report

Grace: Which things on here, where we can have data. More of a review on the financial model. Inform Grace on what would impact these recommendations. Start on the front with the model.
Many things already identified by mission in the report and context about this – that might not be aware of.

All these things could be addressed. A review of the financial modeling. And recommendations in terms of policy changes.

Grace: What would be impacted on these recommendations they made?

Grace: First is Model vs. The Institution Rate of the Long Term Home Health…

Josh: Moving all of home health under CFC. Moving HMA as a separate service.

Grace: Doesn't evaluate the impact.

Josh: Home health substitution rate and moving all health maintenance in home health. A 2nd issue.

Grace: Do you think it's more accurate or putting a policy in place to substitute long term home health?

Josh: They did evaluate what would happen if we substitute all of the HMA portion. There's a factor in there if you substitute 5 or 10% it would reduce CDASS or IHSS. Josh would like to look at if they made the home health benefit at least the majority.

Julie: Everything that's long term home health.

Grace: Maybe we could break it apart.

Josh: We have to have a home health benefit.

Julie: Right now we have a long term home health in acute episode. What if we make it home health as our benefit and put all of that in personal care?

David: State plan has to have home health benefit.

Josh: You can get acute home health for 60 days.

Julie: Anyone in Colorado can get home health. For the people who need nursing level of care.

Julie: Look at what the rate would be and make this a deliverable.

Grace: Evaluate the feasibility of being able to do this. And Look at Different Rates.
** Deliverable- evaluate the impact of moving LTHH

Josh- Mission and the time factor. If we moved home health under personal care rate, it would be a lot cheaper.

#2 (The Model Did not Account For (From Review for CFC Choice Feasibility Analysis.)

<u>Model Assumes that 100% of Services will be receive enhanced match. This is unlikely to be the case.</u>

David- A lot of people who were on the EBD waiver were getting SLS services. Could we explain this and limitations that they would have if on EBD?

Grace: Something Brett could look at.

Carol: A lot of people who on SLS waitlist and on EBD and accessing services through EBD. This is a problem. Because people are transferring over because of CDASS limitations in SLS. We won't get very good data about people who need a lot of personal care services from the last year. As soon as we get CDASS in SLS, we have to make sure we are collecting some data. That understand that transfer rate for these purposes.

David: The current plan from DIDD is personal care is still limited, because HMA is…

Grace: Would that impact CFC?

David: Most of them are going to stay in EBD because they're getting what they need. If they go to SLS, they'll get less.

Josh: They're being double counted.

David: there should be a way of knowing if someone is receiving services but on a waitlist.

Maryjo: We can look at unduplicated data. To see if a person is on one waiver. Eliminate the double county.

Eliminate the Double County within the Waivers/ Waitlist.

Grace- On to #3 and #4: Take-Up Rates for Waivers and The model assumes entirely new clients will have the same take up rate as current waiver clients. This may not be accurate.

Grace: Level of Cost and Interchangeably

Grace: The report didn't account for high utilization

Lori: How many waivers don't have Personal Care? For sure CWA and CHCBS. Pretty sure all the other waivers do have personal care.

Grace: Verify clients that do have personal care.

Josh- Why would you assume to use the highest rate? What was the thought process behind it?

Grace: Have the new contractor, is this the most effective way? Why such a high take up rate?

Josh: how would they look at this with people on waitlist? Who would qualify for EBD.

Carol: As soon as we get CDASS and SLS – we should make sure we are collecting from data.

David: The current plan from CDASS from DIDD – and not personal care.

Grace- would this be an impact on CFC.

David- What would be point of moving if you can't get personal needs met? Need a way of knowing if someone is on a waitlist for a certain waiver.

Grace- the take up rates- and level of cost of how much they would use for this service, the percentage of clients, when someone new comes into the program.

Josh- what defined as personal care. Specific to personal care.

Josh- what is the thought process behind it and was there not as much variation? 15% in one waiver and what in another waiver. What outside the SPAL

Grace- have the new contractor and is this the most effective way.

David- why such a high take up rate? People who need LTSS and not skip home health benefits.

Lori- the higher expenditures

David- seemed very inflates and why such a high take up- rate of CDASS and SLS?

Lori- to look at how people by service dates and the CDASS in SLS. Take up Rates.

Julie- uncomfortable using data in the first year.

Grace- may not be enough time.

Grace- would have access to services now.

Pat- is the service available to them? Having access

Maryjo- provider in the rural area and

Pat- new industry and new people starting.

Lori- how would provider capacity incorporates affect the take up rates and personal care.

Grace:
5,500- Estimated start to have access to services now and the percentage would be the same in the highest waiver. Look at how access to clients in rural areas would impact take up rates.

Maryjo:
Providers in take up rates and being able to provide. Right now there isn't but there eventually may be. If it is in a covered benefit now, there's nobody out there who can buy it if there's no reimbursement for it.

Pat Cook: There hasn't been a huge volume for it in the rural areas to provide for.

Lori: Look at Provider Capacity in Rural and Frontier Areas, to consider.

Candie: It may not be just because it is a rural area, one thing we recently discovered and with long term home health, and budget people looked at people who had access to long term home health through state plan, were not able to get it, until they had IHSS, and they were not all rural people.

Julie: There is a lot of urban people that couldn't get their needs met.

Lori: Why are they using the highest take-up rate and not the average take-up rate?

Josh: Look at Why. Is the highest rate within a couple percent or is it something really broad?

- **What's the difference in the average take up rate and the highest take up rate?**

Carol: When DIDD was using data from 2011, 2012 … and trying to get people emergency services. The only people who got services in this time, were people who had very high needs. Everyone else who qualified and should've been getting services, now there are people who may need only a little bit. Look at level of abundance.

David- They only need a little bit, but for a long time. Or you need a lot.

Grace: Look at high take up rate vs. average take up rate / Was there something externally going on that may not impact regional?

Was there something going on in those years that we need to account for now? Since Medicaid enrollment has gone up overall. If you need long term care you get yourself eligible.

Grace #5: Model Assumes clients who only use services for part of the year will use at the same rate for a whole year to make projections. This may not be accurate.

Lori: People that need LTSS, for the DD population there going to need that care. If they go into acute, it's different.

Julie: This is pretty accurate with the whole population. With elderly people it averages up and down.

Grace #6: Model Assumes that 100% of services will be receive enhanced match. That is unlikely to be the case.

Josh: In the list of services… the…

Grace- that they would all qualify…

Josh- The services that were considered for the report were considered for the CFC. It was a broader set. Non- waiver non-home health and non-waitlist people.

Maryjo: Was this a calculation based on demographic information?

Julie: It was based on adults that came on before ACA and with dependent children. Adults with disabilities. That was the 1,500 people. NWAC.

Josh: If that number was there then, is it still true today?

Grace: Do you think there are people out there who don't access services because they'd rather get them from their family members?

Julie: No, not because they'd rather. I think that there are people who don't quite need nursing level of care or they don't know how to articulate it. If you're a younger disabled person on the EBD waiver and you need that stuff on a regular basis, and not with CDASS, and you need that personal care. You're not going to get it without skilled. We don't have it set up for people outside of CDASS, for personal care/homemaker stuff… if you need it, you don't get it.

Pat Cook: It will be interesting to see in the ACA and the acute world and those home care plans.

Grace: Look at the ACA and how people access services.

Julie- personal care and a higher

Pat Cook: and people who start in the acute world and j tubes and look at how the affordable care act and people who didn't have insurance. And how it affects people who need to get their acute care needs met.

Grace: Do you think how making services accessible was considered in the first study? The 1,500 number?

Grace- how access to health insurance will affect CFC.

Lori: Don't believe access and provider capacity was in the first one.

Maryjo- There was also assumption if there was reimbursement for it, there would be providers.

Pat Cook: How will maintain in personal care at home? What will they be like when this program grows? 40-60 people… for Medicare and every and now more people coming in with insurance and to see how the medical

Julie- we have the physician's attestation. Getting all the medical stuff out. In CDASS. We don't have a lot of paperwork.

David- in home health, we have it every 60 years.

Julie- are you competent to direct your own care in CDASS, is what doctors need to know.

Julie- For administration with HCPF. Are there other entities that could be affected? Will this bring on a higher work load for the SEPs or the CCBs? And do we need to account for it?

Grace #8: for ILST

Grace: For BI, they did it for 10%. They thought they would use it at a higher rate.

David: 10% may still be a little bit high.

Josh: I thought this would be one we would put a cap on it, so everybody could access it a little and for people who needed it more…

Julie- The people I know who are on the BI waiver, they don't use it for intent, they use it for extra personal care. To take someone out to movie. It's for companionship; that people seem to really need.

David- Let's make it be something that becomes useful and teaches real skills and independent living skills.

Anaya- More strict in the CCT services.

Grace- currently it's being used at a higher rate. Do you think it's safe to keep it at what they have it?

Josh: Or do we want this to be a service under CFC or not at the 10% take up rate?

Julie: Do we say that Personal Care needs to include 2 hours a week of want, and say everyone needs a couple hours a week for that support to do something that they want to do together?

#9. Level of cost (LOC) –

Calculated as the maximum, the mean the average. Or the minimum from the least expensive waiver that offers the service, applied to the 4 types of clients.

Grace: For Clients who are receiving LTHH…?

Pat Cook: Do we have utilization available for this. Already done to compare/contrast? Moved from one waitlist?

Julie: not with enough tie - in.

Josh- a client eligible on waiver one. Or of one and three. Or the highest?

Highest is- the highest cost in the highest need waiver.

Josh- Personal care varies greatly between waivers. And all the personal care averages together.

Comparing all of them.

Grace- all the 3 different ways of doing it. Applied all prospective clients.

Maryjo- the rates are different across waivers. It provides as much information as you get from any other method. What's the impact and the variation? What is the value of looking at this? To base costs on current rates is going to be very tough.

Grace- what's the variation? The value of looking at it.

Personal Care Rates.

Josh:
Have to do some of it to project cost. Be transparent. A personal care of rates. May be perhaps higher and rather than in a waiver where it's a flat rate. A reasonable approach. Don't understand number 9. Bearance in cost. The numbers between waivers is very greatly. Projecting their cost for personal care and their cost for all the waivers, or what are the average support levels and projecting cost to someone who is more likely at a lower rate. Under or overestimating cost? What are the other average support levels?
EBD is more average a year for cost, is three or four times as much in comparison to SLS.
Then we are over exaggerating our cost.

Grace- Have the contractor look at and determine is this an effective way to look at cost?

Julie- the rate is such a problem. And the travel time. And the real way

Grace- For #9- in CDASS you get a much more real number- and the skilled – unskilled care.

Have contractor Bret evaluate the method used.

Time Ended. 3:00pm meeting adjourned. Next Meeting in May 2015.